MUNICIPAL PLAN COMPARISON TEMPLATE (AS OF JULY 1, 2008)

Indemnity, PPO & POS Options For Employees and Non-Medicare Retirees & Survivors:

	Municipal Plan		*GROUP INSURANCE COMMISSION PLANS*								
			Harvard Pilgrim Health Care Independence Plan		**Tufts Health Plan Navigator**		**UniCare State Indemnity Plan PLUS**		**UniCare State Indemnity Plan Community Choice**		**UniCare State Indemnity Plan Basic (With CIC)**
Plan Type	**POS**		**PPO**		**PPO**		**PPO-type**		**PPO-type**		**Indemnity**
Coverage Area											
Not Available In These Counties					Dukes and Nantucket		Dukes and Nantucket		Nantucket		
Key Cost Features											
Monthly Premium											
Individual			$513.54		$486.23		$521.79		$410.94		$753.25
Family			$1,242.54		$1,173.51		$1,245.24		$986.24		$1,758.57
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Calendar Year Deductible			***Note:*** *Deductibles for mental health and substance abuse services accumulate separately from the deductibles for other medical services*								
Individual			None	$150 outpatient; Emergency room services do not apply	None	$150	None	$100	None	None	None
Family			None	$300 outpatient; Emergency room services do not apply	None	$300; Two members of a family must satisfy a $150 member deductible	None	$200	None	None	None
Out-of-Pocket Maximum											
Individual			None	$3,000; Doesn't include copays for office visit, hospital, ER, drugs or for skilled nursing facility coinsurance	None	$3,000	$750; Applies to home health care, prosthetics, braces and allergy serum	$3,000	$750; Applies to home health care, prosthetics, braces and allergy serum	$5,000	$750; Applies to home health care, prosthetics, braces and allergy serum
Family			N/A	N/A	N/A	$3,000	N/A	N/A	N/A	N/A	N/A
Lifetime Maximum											
Individual			None	None	None	None	None	None	None	None	None
Family			None	None	None	None	None	None	None	None	None
Physician's Office Services											
Primary Care Physician Office Visit											
Tier 1 "Excellent"			$15 copay	20% after annual deductible	$15 copay	20% after annual deductible	$10 copay	$10 copay then 20% coinsurance	$10 copay	$10 copay	$10 copay
Tier 2 "Good"			No tiering	20% after annual deductible	No tiering	20% after annual deductible	$20 copay	$20 copay then 20% coinsurance	$20 copay	$20 copay	$20 copay
Tier 3 "Standard"			No tiering	20% after annual deductible	No tiering	20% after annual deductible	$25 copay	N/A	$25 copay	N/A	$25 copay
Physician's Office Services Continued											
Specialist Office Visit											
Tier 1			$15 copay	20% after annual deductible	$15 copay	20% after annual deductible	$15 copay	$10 copay then 20% coinsurance	$15 copay	$10 copay then 20% coinsurance	$10 copay
Tier 2			$25 copay	20% after annual deductible	$25 copay	20% after annual deductible	$20 copay	$20 copay then 20% coinsurance	$20 copay	$20 copay then 20% coinsurance	$20 copay
Tier 3			$35 copay	20% after annual deductible	$35 copay	20% after annual deductible	$35 copay	N/A	$35 copay	N/A	$30 copay

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Hospital Services											
Emergency Room Copay			$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay then 20% coinsurance	$50 copay	$100 copay	$50 copay
Copay Waived if Admitted?			Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Per Admission											
Tier 1			$300 copay	20% after annual deductible	$200 copay	20% after annual deductible	$250 copay	$400 copay then 20% coinsurance	$200 copay	$750 copay	$200 copay
Tier 2			N/A	20% after annual deductible	$400 copay	20% after annual deductible	$400 copay		N/A	N/A	N/A
Copay Limits			Four copays per calendar year; Waived if readmitted within 30 days	None	Four copays per calendar year; Waived if readmitted within 30 days	None	One admission copay during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge	None	One admission copay during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge	None	One admission copay for during any given quarter of the year; Copays are waived for readmissions within 30 days of discharge
Outpatient Surgery			$100 copay	20% after annual deductible	$100 copay	20% after annual deductible	$100 copay	$75 copay then 20% after annual deductible	$100 copay	$250 copay	$100 copay
Copay Limits			Four copays per calendar year	None	Four copays per calendar year	None	One outpatient surgery copay per quarter of the year	None	One outpatient surgery copay per quarter of the year	None	One outpatient surgery copay per quarter of the year
Diagnostic X-Ray and Lab Service			No copay	20% after annual deductible	No copay	20% after annual deductible	No copay	20% after annual deductible	No copay	$50 copay	No copay
Rehabilitation Hospital			No copay	20% after annual deductible	No copay	20% after annual deductible	$200 copay	$400 copay then 20% coinsurance	$200 copay		$150
Benefit Limits			No limits	No limits	No limits	No limits	No limits	No limits	No limits	No limits	No limits
Skilled Nursing Facility Copay			20%	20% after annual deductible	20% copay	20% after annual deductible	20%; Does not count toward the annual out-of-pocket maximum		20%; Does not count toward the annual out-of-pocket maximum		20%
Benefit Limits			45 days; Combined in and out of network limit		45 days; Combined in and out of network limit		45 days; Combined in and out of network limit		45 days; Combined in and out of network limit		45 days
Physical Therapy, Occupational Therapy & Chiropractic Treatment											
Physical Therapy			$15 copay	20% after annual deductible	$15 copay	20% after annual deductible	$15 copay	$15 copay	$10 copay	$10 copay	$15 copay
Annual Visit Limits			Up to 90 consecutive days following illness or injury		Up to 90 consecutive days following illness or injury		None	None	None	None	None
Occupational Therapy			$15 copay	20% after annual deductible	$15 copay	20% after annual deductible	$15 copay	$15 copay	$10 copay	$10 copay	$15 copay
Annual Visit Limits			Up to 90 consecutive days following illness or injury		Covered for up to 90 consecutive days per injury or illness		None	None	None	None	None

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	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Chiropractic Services			$15 copay	20% after annual deductible	$15 copay	20% after annual deductible	$10 copay then 20% coinsurance; $40 maximum reimbursement per visit		$10 copay then 20% coinsurance; $40 maximum reimbursement per visit		20% coinsurance
Annual Visit Limits			20 visits per year	20 visits per year	20 visits per year	20 visits per year	20 visits per year		20 visits per year		20 visits per year
Mental Health Services [1]											
Separate Mental Health Deductible			Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mental Health Calendar Year deductible			None	$150, Single $300, Family	None	$150, Single $300, Family	None	$150, Single $300, Family	None	$150, Single $300, Family	$150, single $300, family
Mental Health Out of Pocket Maximum			$1,000, Single $2,000, Family	$3,000 per member	$1,000, Single $2,000, Family	$3,000 per member	$1,000, Single $2,000, Family	$3,000 per member	$1,000, Single $2,000, Family	$3,000 per member	$3,000 per member
In-patient treatment; biologically-based illness			$200 copay; Maximum of four copays per year	$150 copay then 20% copayment after annual deductible	$200 copay; Maximum of four copays per year	$150 copay then 20% copayment after annual deductible	$200 copay; Maximum of four copays per year	$150 copay then 20% copayment after annual deductible	$200 copay; Maximum of four copays per year	$150 copay then 20% copayment after annual deductible	$150 per quarter inpatient copay
Annual Visit Limits			None	None	None	None	None	None	None	None	None
Out-patient treatment; biologically-based illness			$10 for group visits; $15 for individual visits	20% after deductible for visits 1-15; 50% after deductible for visits 16 and after	$15 for individual/family; $10 for medication management; $10 for group therapy	20% after deductible for visits 1 through 15, 50% after deductible for visits 16 and over	$15 for individual/family; $10 for medication management; $10 for group therapy	20% for visits 1-15; 50% for visits 16+	$15 for individual/family; $10 for medication management; $10 for group therapy	20% coinsurance for visits 1-15; 50% coinsurance for visits 16+	$15 for individual/family therapy; $10 for medication management; $10 for group therapy
Annual Visit Limits			None	None	None	None	None	None	None	None	None
Pharmacy Services											
Retail Copay (30 day supply)											
Value Tier							$2	No Benefit	$2	No Benefit	$2
Tier 1			$10	No Benefit	$10	No Benefit	$7	No Benefit	$7	No Benefit	$7
Tier 2			$20	No Benefit	$20	No Benefit	$20	No Benefit	$20	No Benefit	$20
Tier 3			$40	No Benefit	$40	No Benefit	$40	No Benefit	$40	No Benefit	$40
Mail order Copay (90 day supply)											
Value Tier							$4	No Benefit	$4	No Benefit	$4
Tier 1			$20	No Benefit	$20	No Benefit	$14	No Benefit	$14	No Benefit	$14
Tier 2			$40	No Benefit	$40	No Benefit	$40	No Benefit	$40	No Benefit	$40
Tier 3			$90	No Benefit	$90	No Benefit	$90	No Benefit	$90	No Benefit	$90
Routine Vision Care											
Coverage			Yes		Yes		Yes		Yes		Yes
Frequency			Once every 24 months		Once every 24 months		Once every 24 months		Once every 24 months		Once every 24 months
Member Responsibility			$15	20% after annual deductible	$15	20% after annual deductible	$20		$20		$20

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Additional Services Does plan cover infertility services?			Yes		Yes		Yes		Yes		Yes
Frequency limitations on infertility services			Lifetime limit of 5 ART cycles per person		When approved in advance covers a maximum of 5 ART cycles per person, per lifetime		Maximum limit of 5 ART cycles per person per lifetime		Maximum lifetime limit of 5 ART cycles per person per lifetime		Maximum of 5 ART cycles per person per lifetime
Does plan cover other reproductive services including birth control and abortion services?			Yes		Yes		Yes		Yes		Yes
Hearing Aid Benefit			Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500		Every two years plan pays for first $500 of expense and 20% coinsurance of next $1,500
Ambulance Service			None	20% after annual deductible	None		None		None		None
Gym Membership Benefit			None		$150 gym membership reimbursement per household		None		None		None

The information contained in this spreadsheet is for illustrative purposes only and based on publicly available information. The detailed plan design information for the Group Insurance Commission (GIC) plans and/or the municipal plan(s) has not been approved by either the GIC or the GIC's insurance carriers or by the municipality or the municipality's insurance carriers. Complete information about specific benefits is contained in the Summary Plan Descriptions for each program, which are available from the GIC and/or from the municipality. Boston Benefit Partners, LLC does not represent or warrant that the information provided herein specifically reflects any program.